Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ACCESS MEDIQUIP LLC
PO BOX 421529
HOUSTON TX 77242

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-09-6506-01

MFDR Date Received
MARCH 2, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Billed 16 implantable electrodes based on TWCC guildlines [sic] fee schedule Reimbursement per electrode not array Billed implantable neurostimulator charging system Procedure is paid separately not included or global per TWCC guildlines [sic]"

Amount in Dispute: $9,829.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual is willing to settle this dispute by paying an additional amount on codes L8680 and L8689 but not L9900."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2008	HCPCS Codes L8680, L8689, L9900	$9,829.69	$9,354.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of medical treatment/services.
3. 28 Texas Administrative Code §134.1 sets out the procedures for fair and reasonable reimbursement.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 10, 2008 and January 28, 2009

- 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 426 – Reimbursed to fair and reasonable.
- 793 – Reduction due to PPO contract. PPO contract was applied by Focus/Beech Street.
- 97 – The benefit for this service in included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- 891 – The insurance company is reducing or denying payment after reconsideration.
- An implantable neurostimulator electrode, each: is a single implantable electrode array (i.e., cathether, plate) that may contain multiple contacts. Within the context or an implanable neurostimulator. Electrode, each: Regardless of the number of contracts, only 1 implantable neurostimulator electrode may be billed for a dual array pulse generator (L8685 or L8686).

Issues

1. Did the respondent reimbursement the requestor in accordance with the fee guideline?
2. Did the requestor support fair and reasonable in regards to a HCPCS code that is not valued?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed 16 electrodes using HCPCS Code L8680; the respondent reimbursed the requestor for one (1) electrode stating, "An implantable neurostimulator electrode, each: is a single implantable electrode array (i.e., cathether, plate) that may contain multiple contacts. Within the context or an implanable neurostimulator. Electrode, each: Regardless of the number of contracts, only 1 implantable neurostimulator electrode may be billed for a dual array pulse generator (L8685 or L8686)." According to the 2008 HCPCS Level II code book HCPCS Code 8680 is defined as an implantable neurostimulator electrode, each. In accordance with 28 Texas Administrative Code §134.203(b)For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1)Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers… In accordance with 28 Texas Administrative Code §134.203(d)(1) the MAR for HCPCS Level II codes A, E, J, K, and L shall be determined at 125 percent of the fee listed for the code in the DMEPOS fee schedule. Review of the submitted documentation shows the respondent paid for one (1) electrode. As a result, the amount due is $7,481.25 ($399.00 x 125% = $498.75 x 15).

   The requestor billed one unit of HCPCS Code L8689. This code is defined as an external recharging system for battery (internal) for use with implantable neurostimulator. The respondent denied payment for this code using payment exception code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 217 – "The value of this procedure is included in the value of another procedure performed on this date." In accordance with 28 Texas Administrative Code 134.203(b) there are no CCI edits for this particular code; as a result, the amount due is $1,872.93 ($1,498.34 x 125%).
2. The requestor also billed 2 units of HCPCS Code L9900 defined as orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code. The respondent denied payment for this code using payment exception code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 217 – "The value of this procedure is included in the value of another procedure performed on this date." In accordance with 28 Texas Administrative Code 134.203(b) there are no CCI edits for this particular code. In accordance with 28 Texas Administrative Code 134.203(d)The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1)125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;(2)if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3)if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section. Section (f) of this title states that for products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement). Medicare and Texas Medicaid have not assigned a value, as a result this code relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 Texas Register 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided

through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute; the requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement; and the requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

3. Review of the submitted documentation finds that the requestor is entitled to reimbursement for HCPCS Codes LL8680 and L8689 only.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 9,354.18.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,354.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 8, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.